UTAH PUBLIC MENTAL HEALTH SYSTEM
Preferred Practice Guidelines
Updated 11/13/01
Reactive Attachment Disorders in Children

Problems associated with attachment difficulties and disruptions occurring in early years may persist throughout childhood and adolescence. It is imperative that treatment be provided with full cognizance of the history of early attachment difficulties and actively include a parent or parent figure. Treatment must be highly individualized to the child and his/her family.

OPTIMAL OUTCOME OF TREATMENT

The child shall attain a level of functioning that enables him/her to develop attachment and maintain positive relationships within a family system; progress through school; establish appropriate peer relationships; and participate appropriately in social and recreational functions and activities. This level of functioning is agreed upon by parents/guardian, clinical team, involved others and child, as appropriate. Family members will gain skills to implement behavioral interventions within a supportive structure, that provides nurturing guidance, and the positive assurance that will be required to maintain the child/youth, manage challenging situations, and recognize indicators of emerging manifestations and symptoms that will require assessment and intervention modifications.

ASSESSMENT GUIDELINES (See Assessment Guidelines for Children/Youth)

Problems associated with attachment difficulties are difficult to define and, as yet, have not been described in the research. Additionally, there are co-morbid diagnostic manifestations associated with this disorder. Unless the diagnosis was made prior to age five, symptoms, profile and history must exist before the age of five. Older children should receive a diagnosis based on their current emotional and behavioral symptoms. Assessment of children under age five, as well as, older children who experienced early attachment difficulties or disruptions involves gathering data from multiple sources. The child and family history is critical to diagnosis and treatment. Whenever possible, the immediate and extended family members, as well as, other early caregivers of the child should be consulted. In addition, information should be sought from primary sources in schools, caseworkers, health care, and other significant service providers.

1. "Essential features of Reactive Attachment Disorder is markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age five and is associated with grossly pathological care." DSMIV

2. In order to make the diagnosis, a history of maltreatment or neglect with a consequent adverse impact on the child's ability to form trusting relationships must be established.

3. The family will play a vital role in diagnosis and treatment. Efforts should be made to obtain as much information as possible about the child to include developmental milestones, psychiatric and medical history, parental/family medical, psychiatric, genetic history and their impact on child/youth; family substance abuse history; traumatic circumstances including child abuse, domestic violence, removals from the home, disrupted placements, family perceptions of the child/youth and his/her difficulty, perceptions of the parent's role relative to the child's difficulty, and degree of "victimization" felt by the parent(s) of the child. In addition, the assessment must focus on family and extended family relationships, responsibilities, and upon the naturally occurring community supports. Examples of tools for assessment are the Family Perception of Care Scale and the Family Stress Index.

   Assess for co-morbidity with mood disorders, substance abuse, developmental disorders, learning disabilities, communication disorders, intellectual impairment, and psychosis. Follow up on family history i.e., mental illness, substance abuse and genetics.

4. At intake, children and youth presented with possible Reactive Attachment Disorders should be assessed for possible dangerousness to self and others. Immediate intervention should be provided as needed and a crisis plan should be developed.

5. Drug screens should be done as indicated. For adolescents, standardized screening tools (such as the Adolescent Substance Abuse Subtle Screening Inventory—SASSI) may be helpful in identifying substance abuse.

6. Assessment of children who experience attachment difficulties or disruptions involves gathering data from multiple sources with particular emphasis on immediate and extended family members as well as other early care givers of the child. In addition, information should be sought from primary sources in schools, caseworkers, health care, and other significant service providers.

7. Assessment strategies for diagnosing trauma and maltreatment in children should be developmentally appropriate and should use a variety of techniques and settings, such as observing interactive play, caregiver-child interaction across situations and/or settings such as school and independent play.

8. Assessment should include the ability to 1) empathize with others, 2) control impulses, and 3) feel remorse. Assessment should address traumatic events such as prolonged separation, removal from home, exposure to multiple caregivers, maltreatment, neglect, and exposure to domestic violence.

TREATMENT GUIDELINES (See Treatment Guidelines for Children and Youth)

1. Treatment strategies for Reactive Attachment Disorder needs to focus on helping the child develop trusting, secure relationships with significant others. Attachment theory should be utilized to help guide the treatment process to help facilitate the parent-child relationship. Treatment is a process and a number of therapeutic strategies can be used to positively impact the parent/child relationship. A multimode approach should be utilized to achieve optimal outcomes including parent-child treatment, psychodynamic therapy, play therapy, filial therapy, family therapy, cognitive therapy, and behavioral strategies. The treatment goals should be based on the developmental age of the child.

2. No coercive methods of treatment will be approved, whether performed by a therapist or caregiver, when the treatment involves the use of coercive physical constraints to evoke a child's rage or cause a child to undergo a "rebirth" experience. ~~that could be misconstrued by the child as physical pain~~. Coercive treatment methods of this type are not to be confused with appropriate treatment methods used to intervene with a child who has become a danger to themselves or others in a therapeutic environment.

3. Of utmost importance is for the parents to gain the skills requisite for managing the chronic nature of this disorder. It is critical that parents learn that the child's acting out is directed at testing the parent-child relationship due to the child's history of mistrust and neglect. The acting out is not actually a vendetta against the parent. They will require high levels of support and respite services using formal and informal supports. Multiple family placements of the child should be strongly discouraged.

4. Treatment goals should be based on the developmental age of the child. Parents will need to learn the skills to manage the chronic nature of this disorder. Multiple family placements of the child should be strongly discouraged for those who are removed from their natural home setting.

5. The treatment should be individualized emphasizing the underlying issue of trauma and attachment and presenting behavioral manifestations.

6. Intervention should emphasize both the immediate episode of treatment, as well as, the long-term nature of care.

7. Family involvement is critical. Family Therapy and Family Support are essential components. The education of parents around the underlying attachment issues and the subsequent manifestations are essential. The use of their relationship as a positive corrective experience in changing the relationship patterns of their child will require insight and support over time.

8. Behavioral interventions must be used judiciously with an understanding that the underlying emotional problems must be carefully addressed. Focusing solely on the behavior may result in high levels of frustration for the child and the parent.

9. Skills development for both the child and family members should be incorporated. Observing the child/parent interaction and then coaching the parent in providing corrective behavioral interventions is recommended while utilizing an understanding, empathic approach to the child.

10. Individual family therapy should include issues around the parental perception and experience of the child. Therapy should also address issues of victimization, betrayal, trust, anger, and hostility in a supportive manner. Family support groups that focus on positive, as well as, negative experiences should be provided as essential components of treatment.

11. Respite in formal and informal settings is a recommended service for the family and the child. When used, this resource empowers the family to develop a support team.

12. Role models with peer and adult mentors for the child are recommended.

13. The following are treatment considerations: Structure and consistency; parent-child interaction therapy; wraparound planning should help with containment for safety; medicate only for co-morbid conditions, not attachment issues; case management with school for continuity is helpful; look for environmental antecedents to troubling behaviors and make direct interventions; teach parent(s) about redirecting behavior and utilizing natural consequences.